Los Angeles Firemen's Relief Association
Widows, Orphans & Disabled Firefighter's Fund
P. O. Box 41903
Los Angeles, CA 90041
(800) 244-3439 or (323) 259-5200 x223 or x222
www.lafra.org

NIOD Statement

Member Information:

Member's Full Name	Social Security Number	Birth Date	Today's Date

Address	City	State	Zip

Telephone Number	Email Address	Marital Status	Status
			☐ Active - Assignment: ☐ Retired ☐ Spouse

I, _____, state that the Relief claim I am filing for
(Full Name)

_____, is an NIOD illness/injury.
(Name of illness or injury)

If the illness or injury is changed to IOD, all Relief Benefits paid to me will be refunded to the Los Angeles Firemen's Relief Association. I will protect LAFRA's right to reimbursement by pursuing appropriate legal remedies and recognize LAFRA's right to file a lien in any such proceedings.

_____ _____
Signature Date

Updated: 01/01/2020